NATIONALLY SPEAKING

Treat ing the Whole Child: Rhetoric or Reality?

The question of whether child psychiatry represents an entry level or a specialized area of practice in occupational therapy necessitates the examination of a more fundamental issue: Can an area of practice whose knowledge is basic to the preparation of occupational therapists be considered a specialty?

Knowledge of human development throughout the life cycle is fundamental. It is essential to the identification of the developmental stages in progression, as well as regression and immaturity, in skill and behavior as the result of injury or illness. This knowledge supports our claim that we deal with the whole person—the physical, sensory, perceptual, cognitive, emotional, and social aspects of a person irrespective of any disability. Psychosocial principles in occupational therapy treatment have been and continue to be a cornerstone of entry level practice.

In the first article in this series on practice, Dunn and Rask (1989) identified child psychiatry as an emerging specialty in occupational therapy. It may be an emerging area of specialty, but it certainly is not a new area of practice. In 1947, Gleave identified the characteristics occupational therapists should have to work with children who have behavior problems and mental disorders and also suggested therapeutic approaches and treatment activities.

In the occupational therapy literature of the last 10 years, child psychiatry is not claimed by therapists practicing in either psychiatry or pediatrics. Even more disturbing is the fact that the social and emotional development of children may no longer be a part of pediatric practice.

This article focuses on the contributions of recent occupational therapy literature in the areas of (a) children with emotional problems, (b) the provision of services to these children within the school system, and (c) the knowledge, skills, and preparation necessary for entry level practice. It also identifies issues that must be addressed now and in the future.

Psychiatry and Pediatrics

In the past 10 years, only a few occupational therapy articles have focused on the emotional problems of children. McKibbin and King (1983) described an activity group approach to counseling learning disabled children with emotional problems. A 1987 issue of *Occupational Therapy in Mental Health* was devoted to the evaluation and treatment of adolescents and children (Gibson). This issue included articles on the use of the Model of Human Occupation with children and adolescents (Baron, 1987; Sholle-Martin, 1987), program models for adolescents (Melia & Weikart, 1987; Nelson & Condrin, 1987), and a model for treatment within the public school (Agrin, 1987). Some research articles have focused on specific approaches used with particular groups of children. The use of sensory integrative therapy with autistic children prompted investigations by Ayres and Tickle (1980) and by Nelson, Nitzberg, and Hollander (1980). Relaxation (Kwako, 1980) and electromyographic biofeedback (Crist, 1980) with hyperactive children have also been explored.

The amount of information in textbooks that are available to the student, educator, and practitioner is not much greater. The pediatric textbook *Occupational Therapy for Children* (Pratt & Allen, 1989), contains only a chapter on the emotional problems of children (Cronin & Burrell, 1989). Mosey's 1986 text, *Psychosocial Components of Occupational Therapy*, has one chapter on developmental disabilities. In Tiffany's psychiatric sections of the 1983 edition of *Willard and Spackman's Occupational Therapy* (Hopkins & Smith), children and adolescents are discussed in only a few paragraphs under the heading of "Contexts or Settings for Treatment." The case studies used throughout this chapter are adult focused. Even in the 1988 edition of this text, there is no

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section in the psychiatric chapter focusing on emotionally disturbed children (Schwartzberg & Tiffany, 1988). In the pediatric section of the 1983 and 1988 editions, the social-emotional development of children is not addressed. It does not become an area of treatment focus even with the autistic or abused child (Ramm, 1983a, 1983b, 1988a, 1988b). The book features a comprehensive pediatric evaluation tool, with categories including neuromuscular reflex and gross motor development; physical findings related to posture, muscle tone, range of motion, and adaptive appliances; activities of daily living including feeding, dressing, grooming, and written communication; upper extremity functional activities; and sensory integration. The text suggests that data from this assessment be viewed and interrelated with information about the child's social, cultural, and familial condition, but how this is to be accomplished is not addressed. Another chapter contains a child development chart developed by Kaufman (1983, 1988) that identifies expectations in the areas of general reflex development, sensory development, body scheme, equilibrium, bilateral integration, visual perception, eye-hand coordination, and language from infancy through 12 years of age. Kaufman (1983) stated that "the use of the chart is intended to promote continual awareness in the mind of the therapist of all the goals established for each child, and their interrelationship" (p. 689). If the milestones of social-emotional development are never listed, how can this become an arena for occupational therapy intervention? This absence of social-emotional development is particularly evident in the discussion of abused children. Ramm (1983a, 1988a) listed observable behaviors in young children with a history of abuse or neglect that may indicate a need for referral. These include overly compliant behavior, social withdrawal, lack of autonomy, aggression, apathy, and retarded growth. However, the suggested "comprehensive and complete" assessment of these children under 4 years of age addresses only the following: (a) neurodevelopmental reflex maturational levels, (b) gross motor development, (c) fine motor development, (d) activities of daily living skill development, and (e) sensory integration. The manner in which these children, who have suffered at the hands of another person, relate to others is not assessed or treated. Apparently, the social-emotional development and the social-emotional behavior of children are not matters of concern to some of our most respected colleagues writing for the premier textbook in occupational therapy.

**Occupational Therapy in the Schools**

Occupational therapists working with children in the school setting represent a substantial number of practitioners. In 1982, 18.2% of all full-time therapists were working in the school system (AOTA, 1985). This is due primarily to the 1975 passage of the Education for All Handicapped Children Act (Public Law 94-142), which includes occupational therapy as a related service. The Education of the Handicapped Act Amendments of 1986 (Public Law 99-457) make it likely that the demand for services, along with the number of therapists working with children, will increase. This law requires that special education and early intervention or developmental services be provided to preschool children with disabilities by 1991. Occupational therapy is included in these amendments as a developmental service (Hanft, 1988).

Children with emotional disturbances form the fourth largest handicapped group in the school setting, preceded by children with learning disabilities, speech impairments, and mental retardation (U.S. Department of Education, 1987). But very few occupational therapists work with emotionally disturbed children. The Robert Wood Johnson Foundation (1988) published the findings of a 5-year collaborative study of children with special needs in five large metropolitan school districts across the country. The purpose of the study was to identify the extent to which the procedural guarantees of Public Law 94-142 were in place. The authors of the report cautioned that their findings could not be generalized to the country as a whole. With reference to therapeutic services, the investigators concluded that "nearly half of all children in special education receive speech or hearing therapy, whereas physical and occupational therapy are concentrated on children with physical, vision/hearing, or health impairments, as well as on the mentally retarded" (Robert Wood Johnson Foundation, p. 4).

The extent to which occupational therapists are paying attention to the psychosocial component of children's behavior is insufficient. Within the American Occupational Therapy Association's (AOTA's) Standards of Practice (AOTA, 1986a), the evaluation categories are broad and the psychosocial area is one of the performance components evaluated. Number 4 in the Evaluation subsection is puzzling, however: "If the results of the evaluation indicate possible deficits in psychosocial, cognitive, physical/medical, or speech/language areas, the occupational therapist shall recommend to school personnel that the student be referred to the appropriate services and/or request consultation as indicated" (AOTA, 1986a, p. 4-4). It certainly is advisable to request consultation or to refer to appropriate services when possible deficits in psychosocial areas are identified, but does this mean we have no role in this area? Royeen and Marsh (1988) suggested that occupational therapists are concerned with this area, but only at a sensory-motor processing level. They stated that "occupational therapists are concerned with sensory-motor processing as a substratum of...the child's social/emotional/psychological state" (p. 715). Should we not also be directly concerned with the content and context of children's social and emotional behavior?

The two exceptions to the lack of published programs for emotionally disturbed children in the schools are those by Agrin (1987) and McKibbon and King (1983). Both used task/activity groups. Both had similar goals, because most children diagnosed as emotionally disturbed present similar problems (e.g., cooperating with others; sharing attention, space, and materials; and respecting class members and materials). Agrin stated that school personnel perceived the occupational therapy pro-
program as important because the goals for the students were straightforward and clearly relevant to the development of age-appropriate social skills within the school environment.

Occupational therapists will be working more with disabled children and their families as a result of Public Law 99-457. The particular approach they use with children and their families is critical. Day (1982) found that everyday mother-infant activities such as feeding, holding, and playing provide stimulation to different sensory systems. She concluded that therapists can help parents recognize an infant’s responses to stimulation and adjust their actions to provide the maximum benefit to their infant. Because daily activities can stimulate sensory systems and can provide an opportunity for interactive processes between infants and their mothers, they are a powerful therapeutic tool.

In another program approach, Parush, Lapidot, Edelstein, and Tamir (1987) concluded that “a structured occupational therapy intervention program that uses neurodevelopmental principles of growth and development can enrich parents’ fundamental knowledge about the infant’s sensory-motor capabilities” (p. 605). In AOTA’s roles and functions paper for early childhood intervention (1986c), occupational therapy was described as the use of purposeful activities to promote normal development and coping behaviors. It also stated that “treatment stems from a scientifically based neurophysiological framework” (p. 835). Sensory-motor, neurodevelopmental, and neurophysiological frameworks are valuable bases for practice, but alone they are too narrowly focused to support the claim that we treat the whole child or that we engage the child in purposeful, productive activity. The interactive and engagement processes in human behavior require an entirely different knowledge base.

Knowledge and Skills

Knowledge of the following areas is required for entry level therapists working with emotionally disturbed children:

1. **Human development throughout the life cycle**—the behaviors, stages, and tasks in sensory-motor, cognitive, and social-emotional growth and development expected in infancy, early and middle childhood, adolescence, young and middle adulthood, and old age. Knowledge of what one is building toward is as important as knowledge of what one is building on. The social-emotional growth and development of children needs to be taught within the context of occupational therapy practice areas.

2. **Purposeful activity**—the importance of and expected sequences in the mastery of specific domains of activity such as activities of daily living and the larger domains of play and work or occupation. Knowledge of play and how to assess and evoke it is essential.

3. **Theoretical frameworks**—the importance of practicing within a theoretical framework, the basic tenants of occupational therapy frameworks, the recommended assessments and treatments of these frameworks, and the usefulness and limitations of various frameworks with specific disabled populations.

4. **Psychopathology**—the etiology, characteristics, and course of the major diagnostic categories appropriate for children and adolescents (e.g., conduct disorder, oppositional disorder, attention-deficit disorder, eating disorder, gender identity disorder, and autism).

The following skills are necessary for entry level therapists working with emotionally disturbed children:

1. Observation of behavior and knowledge of the difference between observation and inference.
2. Selection and administration of assessments.
3. Problem identification and analysis to determine the need for and level of intervention.
4. Program planning and implementation, including the determination of discrete goals and objectives that can be implemented individually and in groups in a variety of settings including the home, the school, the neighborhood, and the clinic.
5. Group or behavior management to help children identify the consequences of their actions.

6. Interpersonal relations and communication to make goals or expectations clear to children and to make implementation and follow-up clear to multidisciplinary medical or educational team members and parents.

7. Documentation of assessment and intervention results in a manner appropriate to the setting.

8. Beginning management so that occupational therapy programs can be assessed and evaluated through record-keeping or reporting procedures.

Knowledge and skills are acquired in academic and clinical settings. The ideal preparation for entry level practice includes a clinical affiliation with emotionally disturbed children. For the past 20 years, the University of California–Los Angeles Neuropsychiatric Institute has accepted Level II fieldwork students from curricula across the country. After 8 weeks of supervised fieldwork, most students provide assessments and treatment, document intervention results, and report and integrate treatment with a sophisticated multidisciplinary treatment team. In the remaining weeks of the fieldwork experience, the students refine their skills and knowledge and become more competent and confident. Not all occupational therapy students have a fieldwork experience in child psychiatry. The critical components of psychiatric or pediatric fieldwork include the opportunity to work in a group/task setting and to interact with a multidisciplinary team. The two most prominent treatment settings for emotionally disturbed children are the hospital and the school. Both settings require the planning and integration of occupational therapy with a multidisciplinary team. Because of their psychopathology (e.g., lack of cooperative, sharing behaviors), most children need to be seen in small groups for treatment to be most effective.

Dunn (1988) described three models of consultation used within the educational environment: case consultation, colleague consultation, and system consultation. Entry level practitioners in this area can provide case consultation but colleague and
system consultation are beyond their level of experience, knowledge, and sophistication.

Issues

It seems that child psychiatry is not an emerging area of practice but a forgotten one. It has slipped from psychiatry and has been overwhelmed by the emphasis on sensory-motor and neuromuscular concerns in pediatrics. Child psychiatry needs to be claimed by one specialty area or another. I suggest it be included in pediatrics because an understanding of developmental issues is crucial in work with emotionally disturbed youngsters. The pendulum of the pediatric knowledge base has swung entirely too far in the direction of neuromotor and sensory-motor concerns. It must swing back to include the social-emotional development and behavior of children and adolescents. This will not occur if this important area of development is relegated to the status of a prerequisite educational requirement. The treatment domain of emotionally disturbed children in the school system must be developed, or we risk losing this important area to others.

Major changes must occur not only in the educational preparation of students for practice in child psychiatry, but also their educational preparation for practice in any specialty area. To prepare occupational therapists for the practice arena is our clearest mandate. Many issues are involved, and there are no simple answers to the question of entry level versus advanced level preparation. But something is terribly wrong when research is a major heading in our educational standards (American Medical Association & AOTA, 1983) and when a group of concerned pediatric practitioners mandates a review of the courses taught to prepare students for entry level practice (AOTA, 1986b). Entry level educational standards are vague, but the status of the standards cannot be resolved by educators alone. They have been forced to try to fit the demands of various occupational therapy sectors, along with baccalaureate degree requirements, into already jam-packed curricula. Yerxa and Sharrott (1986) commented on this dilemma: "Educators often feel torn between the demands of a clinical community that seeks graduates who have refined technical skills, a set of 'Essentials', that is so nonspecific as to be of little help in curriculum design, and a lack of clarity regarding the sort of person who should enter practice after graduation" (p. 154).

In 1979, an entire issue of the American Journal of Occupational Therapy (Viseltear, 1979) was devoted to the discussion of specialization and its implications for occupational therapy. In that issue, Fidler (1979) argued that the generic base of education must be identified before specialization and advanced education can be determined. She urged that the content and design of entry level education become AOTA's priority. Clearly, this has not been accomplished.

Conclusion

The rhetoric of occupational therapy is rich and compelling. The Philosophical Base of Occupational Therapy (AOTA, 1979), the definition statements, and the standards of practice all reflect our concern for the whole person with an illness or injury for whom we provide intervention in the form of purposeful activity. The reality of that commitment is measured in practice, but our recent practice suggests that the social and emotional aspects of development of children's behavior has received spotty coverage. Practice is built on educational preparation and experience, and entry level educational experiences are guided by standards that are rich in rhetoric but vague and intangible. These standards will remain ambiguous until we clearly distinguish the body of knowledge for entry level education from the body of knowledge for continuing and graduate education.

References


